STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155769		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2012
	1557.68	B. WING		12/12/2012
	PROVIDER OR SUPPLIER ON WOODS HEALTH CAMPUS	4100 N	ADDRESS, CITY, STATE, ZIP CODE I MORRISON RD IE, IN 47304	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F0000				
	This visit was for the Investigation of Complaint #IN00119473. Complaint #IN00119473-Substantiated. Federal deficiencies related to the allegation are cited at F242 and F246. Survey date: 12/11/12 Facility number: 011596 Provider number: 155769 AIM number: 200901690 Survey team: Shelley Reed, RN Census bed type: SNF: 43 SNF/NF: 10 Residential: 32 Total: 85 Census payor type: Medicare: 23 Medicaid: 7	F0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provide of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint Survey on December 1: 2012. Please accept this plan of correction as the provider's credib allegation of compliance. The provider respectfully requests desk review with paper compliance to be considered in establishing the the provider is in substantial compliance.	an er n 1, de
	Other: 55			
	Total: 85			
	Sample: 3			
LABORATOR	Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	of Correction identification number 155769	CR:	2) MULTIPLE CO. BUILDING WING	00	12/12	LETED 2/2012
	PROVIDER OR SUPPLIER		4100 N	DDRESS, CITY, STATE, ZIP MORRISON RD E, IN 47304	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2					
	Quality review completed 12/28/12 by Randy Fry RN.					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155769	B. WIN	G		12/12/	2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET .	ADDRESS, CITY, STATE, ZIP CODE		
					MORRISON RD		
MORRIS	ON WOODS HEAL	TH CAMPUS		MUNCI	IE, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG F0242	483.15(b)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D	` '	NATION - RIGHT TO					
	MAKE CHOICES						
	The resident has the right to choose activities, schedules, and health care consistent with his or her interests,						
	assessments, and	d plans of care; interact					
	with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility						
	that are significar						
	Based on observa	ation, interview and	F02	42	F 242 Corrective actions		01/11/2013
	record review, the	facility failed to			accomplished for those residents found to be affecte	d	
	ensure the right to choose their own				by the alleged deficient		
	bedtime schedule	for 1 of 1 residents			practice: Resident A's persor		
	reviewed in a sam	pple of 3. (Resident			preferences, including what tin she would like to go to bed, wa		
	A)				updated. Identification of	10	
					other residents having the		
	Findings include:				potential to be affected by the		
	T mamga malada.				same alleged deficient practi and corrective actions taken:		
	During initial tour	on 12/11/12 at 8:45			No other resident's, who reside		
	a.m., Resident A				on the Health Center, receive services on our Memory Care	day	
		ory Care Unit main			Unit. Measures put in place	ļ	
		•			and systemic changes made		
	living room. Durin				ensure the alleged deficient	2	
	current facility cen	•			practice does not recur: DHS or designee will re-educate the		
	was found to not h				Nursing Staff on the following	-	
	_	n the Memory Care			guideline: Bill of Resident's		
		gned a room on the			Rights. How the corrective measures will be monitored to	to.	
	health care side.	Resident (A)			ensure the alleged deficient		
	currently wears a	Wanderguard.			practice does not recur: The	;	
					following observations will be		
	Resident (A)'s dia	gnoses included but			conducted by the DHS or designee 2 times per week tim	ies	
	were not limited to	o; dementia,			4 weeks, then monthly times 5		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	(X2) MULTIPLE (A. BUILDING	OO	(X3) DATE SURVEY COMPLETED 12/12/2012
	PROVIDER OR SUPPLIER		4100	TADDRESS, CITY, STATE, ZIP CODE N MORRISON RD	1
MORRIS	ON WOODS HEAL	TH CAMPUS	MUNC	CIE, IN 47304	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	hypertension, diak	petes and agitation.		9: 00:	
	Resident (A) scored a 3 of 15 for the			All resident's who receive day services on the Memory	
	Brief Interview Mental Status (BIMS)			Unit to ensure their personal	
	on the Minimum Data Set (MDS)			preference / choice of rest till being honored. 2). Will obse	
	assessment dated 10/5/12. A score			residents for any signs /	
	of 3 indicated seve	ere cognitive		symptoms of anxiety, agitation sleepiness or verbal stateme	
	impairment on the	MDS.		of wanting to return to their rofor rest. 3). Will observe to	oom
	During an intervie	w on 12/11/12 at		ensure resident is assisted to their room for rest. The resu	
	10:00 a.m., LPN #	44 indicated		of the observations will be	
	Resident (A) has a room on the 200			reported, reviewed and trend for compliance thru the camp	
	hall but spends he	er day in the		Quality Assurance Committee	
	Memory Care Uni	t because she often		a minimum of 6 months then	
	wanders. She ind	licated the resident		randomly thereafter, for further recommendations.	er
	will occasionally c	ome back to the			
	200 hall to take a	nap. She indicated			
	the resident has n	o behaviors and is			
	pleasantly confus	ed.			
	During an intervie	w on 12/11/12 at			
	10:25 a.m., LPN #	t5 indicated			
	Resident (A) woul	d get agitated and			
	anxious on the 20	0 hall. She			
	indicated the resid	lent did not come			
	back to the 200 ha	all for naps but			
	would often rest ir	a recliner on the			
	Memory Care Uni	t.			
	During an intervie	w on 12/11/12 at			
	10:45 a.m., the He	ealth Facility			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A 4100 N I	DDRESS, CITY, STATE, ZIP CODE MORRISON RD		
MORRIS	ON WOODS HEAL	TH CAMPUS		MUNCIE	E, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Administrator indi	cated the resident					
	has a semi-private	e room on the 200					
	hall, but is kept in the Memory Care						
	Unit from the time	she wakes up until					
	the time she goes	to bed. She					
	indicated the Men	nory Care Unit is a					
	private pay area a	and the resident					
	currently has Med	licaid and the family					
	did not want to move the resident out						
	of the facility, but could not afford to						
	private pay for the Memory Care Unit.						
	She indicated the resident has						
	sundown syndrom	ne and is exit					
	seeking in the late	er part of the day.					
	She indicated she	does not currently					
	have a diagnosis	of sundown					
	syndrome from a	physician. She					
	indicated the loca	l ombudsman has					
	not been involved	with this resident or					
	the current situation	on. She indicated					
	the family is suppo	ortive of the					
	decision to keep t	he resident on the					
	Memory Care Uni	t during the day.					
	During an intervie	w on 12/11/12 at					
	11:35 a.m., QMA	#6 indicated					
	Resident (A) woul	d not go back to					
	200 hall for naps	and there was no					
	place for her to la	y down on the					
	Memory Care Uni	t. Resident (A)					

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	F CORRECTION IDENTIFICATION NUMBER: 155769 A. BUILDING B. WING		COMPLETED 12/12/2012				
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			4100 N	MORRISON RD		
MORRIS	ON WOODS HEALT	TH CAMPUS		MUNCII	E, IN 47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION DATE
	would be taken to	the staff bathroom					
	when needed. QN	MA #6 indicated she					
	was told to not tak	e the resident back					
	to the 200 hall until at 7 p.m. She						
	indicated the resid	lent would often be					
	ready to go lay do	wn after supper on					
	the Memory Care	Unit, but could not					
	return until after 7	p.m.					
	During an interview on 12/11/12 at						
	11:45 a.m., CNA #7 indicated						
	Resident (A) would get upset if she						
	could not go any la	ay down in her					
	room after supper.	. She indicated					
	management woul	ld get upset if					
	Resident (A) was r	returned to the 200					
	hall before 7 p.m.	because the staff					
	were busy finishing	g with supper and					
	could not watch he	er as closely.					
	During an interviev						
	12:00 p.m., Social						
	indicated 7 p.m. w	•					
		(A) would return to					
	the 200 hall. If Re						
	returned prior to 7						
		vior, but was easily					
	redirected.						
	During an interviev	w on 12/11/12 at					

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	OF CORRECTION	i '		(x2) MULTIPLE CONSTRUCTION . DUM DDVG 00			SURVEY ETED
11.512111		155769		LDING		12/12/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				MORRISON RD		
MORRIS	ON WOODS HEAL	TH CAMPUS		MUNCIE	E, IN 47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	12:05 p.m., the Do	· · · · · · · · · · · · · · · · · · ·		mo			DATE
	-	d wander because					
	she was overstimulated on the 200						
	hall. Resident (A) would come back						
	between 6-8 p.m. to go to bed. She						
	indicated she did tell a CNA the						
	resident was not t						
	200 hall prior to 7	p.m., but that					
	employee is no longer employed at						
	the facility.						
	During an interview on 12/11/12 at						
	2:10 p.m., LPN #8	3 indicated the					
	Memory Care Unit	t CNA's get					
	Resident (A) read	y for bed before					
	going back to the	200 hall. She					
	indicated the CNA	s are busier on the					
	200 hall and do no	ot have time to					
	monitor Resident	(A).					
	During an intervie						
	3:55, Resident (A)	_					
		aware her mother					
		Memory Care Unit					
		t was unaware of a					
	concern that her n						
	anxious and agita						
		ted to return to the					
	200 hall to go to b	ed.					

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155769	A. BUI	LDING	00	COMPLE ² 12/12/2	
		155769	B. WIN		DDDDGG GYRY GRADE GYD GODE	12/12/2	012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MORRISON RD		
MORRIS	ON WOODS HEAL	TH CAMPUS			E, IN 47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	During review of c	· · · · · · · · · · · · · · · · · · ·					5.112
	12/11/12, Resider	nt (A)'s record					
	indicated a resident preference for						
	customary routine	and activities					
	worksheet, dated 6/18/12, which was						
	provided by the co	orporate nurse on					
	12/11/12 at 4:40 p	o.m. The record					
	indicated record could not be						
	completed by resident, family or						
	significant other. Review of a						
	conference note dated 6/26/12,						
	indicated the resid	dent required special					
	assistance with su	upervision due to					
	ambulatory cognit	ion and safety					
	concerns.						
	Review of a curre	ent facility policy					
	dated 10/2004 title	ed "Bill of Resident					
	Rights" which was	s provided by the					
	Administrator on 1	12/11/12 at 9:30					
	a.m., indicated the	e following:					
	35. Dignity/Self D	etermination and					
	Participation: You						
	receive care from	•					
	manneryou have	•					
	_	es, schedules, and					
	health care consis						
		nents, and plans of					
	care.						
	l		1				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155769	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP 12/12	LETED 2/2012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
	3.1-3(u)(3)							

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPLETED
		155769	A. BUII B. WIN			12/12/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	S.			MORRISON RD	
MORRIS	ON WOODS HEAL	TH CAMPUS	MUNCIE, IN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY	DATE
F0246 SS=D	NEEDS/PREFER A resident has the services in the far accommodations preferences, exce	e right to reside and receive cility with reasonable of individual needs and ept when the health or ridual or other residents				
		ation, interview and	F02	46	F 246	01/11/2013
	record review, the facility failed to provide reasonable accommodation for 1 of 1 residents reviewed in a sample of 3. (Resident A). Findings include:				Corrective actions	
					accomplished for those	
					residents found to be affecte	d
					by the alleged deficient	.=1
					practice: Resident A's person preferences, including what tin she would like to go to bed, wa updated. Identification of other residents	ne as
	During initial tour	on 12/11/12 at 8:45			having the potential to be	
	a.m., Resident A	was found to be			affected by the same alleged deficient practice and	
	sitting in the Mem	ory Care Unit main			corrective actions taken: No	
	living room. Durin	ng review of the			other resident's, who reside or	
	current facility cer	nsus, Resident A			the Health Center, receive day services on our Memory Care	′
	was found to not h	nave a room			Unit.	
	assigned to her or	n the Memory Care			Management in place and	
	Unit but was assig	gned a room on the			Measures put in place and systemic changes made to	
	health care side.	Resident (A)			ensure the alleged deficient	
	currently wears a	Wanderguard.			practice does not recur: DHS or designee will re-educate the Nursing Staff on the following	
	Resident (A)'s dia	gnoses included but			guideline: Bill of Resident's	
	are not limited to;	dementia,			Rights.	
	hypertension, diabetes and agitation.			How the corrective measures	,	
		ed a 3 of 15 for the			will be monitored to ensure t alleged deficient practice do	he

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		155769	B. WIN			12/12/2012
NAME OF I	DROWINED OR CUIDDLIED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			4100 N	MORRISON RD	
MORRIS	ON WOODS HEAL	TH CAMPUS		MUNCII	E, IN 47304	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
		ental Status (BIMS)		1110	not recur: The following	
	on the Minimum D				observations will be conducted	- 1
	assessment dated 10/5/12. A score of 3 indicated severe impairment on				the DHS or designee 2 times p week times 4 weeks, then monthly times 5 months to ens	per
	the MDS.	•			compliance: 1). All resident's who receives day services on	
					Memory Care Unit to ensure the	I
	During an intervie	w on 12/11/12 at			personal preference / choice of rest time is being honored. 2).	I
	10:00 a.m., LPN #	#4 indicated			Will observe residents for any	
	Resident (A) has	a room on the 200			signs / symptoms of anxiety, agitation, sleepiness or verbal	
	hall but spends he	er day in the			statements of wanting to return	n to
	Memory Care Unit because she often				their room for rest. 3). Will observe to ensure resident is	
	wanders. She inc	licated the resident			assisted to their room for rest.	
	will occasionally c	ome back to the			The manufacture of the color of	
	200 hall to take a	nap. She indicated			The results of the observation will be reported, reviewed and	
	the resident has n	o behaviors and is		trended for compliance thru the		
	pleasantly confus	ed.			campus Quality Assurance Committee for a minimum of 6	
					months then randomly thereaf	
	During an intervie	w on 12/11/12 at			for further recommendations.	
	10:25 a.m., LPN #	#5 indicated				
	Resident (A) woul	d get agitated and				
	anxious on the 20	0 hall. She				
	indicated the resid	dent did not come				
	back to the 200 ha	all for naps but				
	would often rest ir	n a recliner on the				
	Memory Care Uni	t.				
	During an interview on 12/11/12 at					
	10:45 a.m., the He	ealth Facility				
	Administrator indi	cated the resident				
	has a semi-private	e room on the 200				

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	PROVIDER OR SUPPLIER		B. WIN	STREET A 4100 N I	DDRESS, CITY, STATE, ZIP CODE MORRISON RD		
MORRIS	ON WOODS HEAL	TH CAMPUS		MUNCIE	E, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	hall, but is kept in	the Memory Care					
	Unit from the time	she wakes up until					
	the time she goes to bed. She						
	indicated the Men	nory Care Unit is a					
	private pay area a	and the resident					
	currently has Med	licaid and the family					
	did not want to mo	ove the resident out					
	of the facility, but	could not afford to					
	private pay for the Memory Care Unit.						
	She indicated the resident has						
	sundown syndrome and is exit						
	seeking in the later part of the day.						
	She indicated she	does not currently					
	have a diagnosis	of sundown					
	syndrome from a	physician. She					
	indicated the local	l ombudsman has					
	not been involved	with this resident or					
	the current situation	on. She indicated					
	the family is suppo	ortive of the					
	decision to keep t	he resident on the					
	Memory Care Uni	t during the day.					
	During an intervie	w on 12/11/12 at					
	11:35 a.m., QMA	#6 indicated					
	Resident (A) woul	d not go back to					
	200 hall for naps a	and there was no					
	place for her to lag	y down on the					
	Memory Care Uni	t. Resident (A)					
	would be taken to	the staff bathroom					
	when needed. Qf	MA #6 indicated she					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL			
155769		A. BUI B. WIN	LDING G		12/12/	2012		
NAME OF BROWINGS OR CURBLIED			J. ,, 11.		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			4100 N MORRISON RD					
MORRISON WOODS HEALTH CAMPUS				<u> </u>	E, IN 47304		715)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE	
	was told to not tak	te the resident back						
	to the 200 hall unt	il at 7 p.m. She						
	indicated the resid	dent would often be						
	ready to go lay down after supper on							
	the Memory Care	Unit, but could not						
	return until after 7	p.m.						
	During an intervie							
	11:45 a.m., CNA #7 indicated							
	Resident (A) would get upset if she							
	could not go any lay down in her							
	room after supper							
	management wou	-						
		returned to the 200						
	hall before 7 p.m.	because the staff						
	were busy finishin							
	could not watch her as closely.							
	Dania a sa intensie	40/44/40 -1						
	During an intervie							
	12:00 p.m., Socia							
	indicated 7 p.m. was the time they decided Resident (A) would return to							
	the 200 hall. If Resident (A) was							
	returned prior to 7 p.m., she would							
	often have a behavior, but was easily							
	redirected.							
	During an intervie	w on 12/11/12 at						
	12:05 p.m., the DoN indicated Resident (A) would wander because							
							l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155769		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2012		
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ulated on the 200 would come back					
	` '						
	between 6-8 p.m. to go to bed. She indicated the resident has never been						
	out of the facility b	out will occasionally					
	be seen by the do	-					
	indicated she did	tell a CNA the					
	resident was not t	o be returned to the					
	200 hall prior to 7 p.m., but that						
	employee is no longer employed at						
	the facility.						
	During an interview on 12/11/12 at						
	2:10 p.m., LPN #8	3 indicated the					
	Memory Care Uni	t CNA's get					
	Resident (A) read	y for bed before					
	going back to the	200 hall. She					
	indicated the CNA	s are busier on the					
	200 hall and do no	ot have time to					
	monitor Resident (A).						
	During an interview on 12/11/12 at						
	3:55, Resident (A)'s daughter						
	indicated she was aware her mother						
	was placed on the Memory Care Unit						
	during the day, but was unaware of a						
	concern that her mother became						
	anxious and agita	ted after dinner					
	because she wan	ted to return to the					
	200 hall to go to bed.						

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		IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
155769			LDING		12/12/		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER					MORRISON RD		
MORRISON WOODS HEALTH CAMPUS					E, IN 47304		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710	REGUENTORT OR	ESC IDENTIFY TING INFORMATION)		1710	<u> </u>		DATE
	During review of c	slinical record on					
	12/11/12, Resider	nt (A)'s record					
	indicated a reside	nt preference for					
	customary routine	and activities					
	worksheet, dated	6/18/12, which was					
	provided by the co	orporate nurse on					
	12/11/12 at 4:40 p	o.m. The record					
	indicated record could not be						
	completed by resident, family or						
	significant other. Review of a						
	conference note dated 6/26/12,						
	indicated the resident required special						
	assistance with supervision due to						
	ambulatory cognition and safety						
	concerns.						
	Review of a curre						
	dated 10/2004 titled "Bill of Resident						
	Rights" which was provided by the						
	Administrator on 12/11/12 at 9:30						
	a.m., indicated the following:						
	38 You have the	right to reside and					
	38. You have the right to reside and						
	receive services in the facility with reasonable accommodation of						
	individual needs and preferences						
		health or safety of					
		ould be endangered.					
	- 1						

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	OF CORRECTION	IDENTIFICATION NUMBER: 155769	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 12/12	LETED		
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	3.1-3(v)(1)							

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